flu-like symptoms and anorexia are often difficult to distinguish from mild depression—ubiquitous among such cultures—and/or undernutrition or malnutrition. Low grade fevers are not uncommon in hospital admissions, particularly when there is associated subacute bronchitis or pelvic inflammatory disease—again, often the case with this group. It is thought that many commune cultures are fairly comfortable with diagnosing and managing infectious hepatitis among their members, since most are cognizant of its usually non-fatal, limited and relatively benign course. This, coupled with the realization that medical science has little in the way of real relief or cure to offer, means that most cases of "the hep" are not seen by doctors except by chance as in the situation where hospital admission for other reasons becomes mandatory. Routine chemical panel screening tests become mandatory at that point.

NORMAN C. HEADLEY, M.D.

REFERENCE

Schiff L: Diseases of the Liver—3rd ed. Philadelphia, J. B. Lippincott Co, 1969

Epidemic Gonorrhea

Today in California the problems of venereal disease are becoming the major public health problem in young people (under 25 years). Half a million cases of gonorrhea in California are predicted by the State Department of Public Health this year.

Venereal disease is the Number One reportable communicable disease nationally and is primarily (80 percent) treated by the private physician. We must suspect it, recognize it, diagnose it, and treat it.

In addition to this, we must attempt to prevent it. The International Venereal Disease Symposium in St. Louis stated that "the lag between public concern and organized action must be shortened." We cannot afford to be Victorian in our attitude toward VD when sexual permissiveness continues to increase.

The primary factors are awareness of the problem, education of the public, detection of cases, adequate treatment and contact follow-up. The family physician can be instrumental in controlling this epidemic.

SIMON C. BRUMBAUGH, JR., M.D.

REFERENCES

San Diego's Health. San Diego County Department of Public Health Bulletin, 19: April 1971

International Venereal Disease Symposium, St. Louis, 1971—Cosponsored by the American Social Health Association and Pfizer Laboratories

Incidental Hypokalemia in Ambulatory Patients

The increasing use of automated laboratory screening panels are identifying more patients with incidental hypokalemia. Physicians are alert to the possibility of hypokalemia in digitalis intoxication, in gastrointestinal fluid loss and in the potential hypokalemia resulting from diuretic administration.

But hypokalemia may occur as a result of adrenal steroid therapy and in the intrinsic adrenal diseases Cushing's syndrome and primary or secondary aldosteronism. Other causes are primary renal disease and ingestion of outdated tetracycline (although the mode of action in this latter cause is not known).

The gravity of unrecognized hypokalemia is highlighted by reports from coronary care units of patients admitted with repetitive cardiac arrhythmia who do not respond to any therapy, including countershock, until the electrolyte deficiency is recognized and treated.

Physicians should be alert to other hidden causes of hypokalemia—that is, laxative-induced diarrheas, self-induced vomiting, and persistent rectal discharge from colon disease.

In non-emergency cases, hypokalemia can be treated orally by the administration of 40 mEq of elemental potassium per day. Further adjustment of dosage should be determined by electrolyte monitoring. Caution must be used in potassium supplementation, as the amount of deficiency or daily dosage is not accurately known.

WILFRED SNODGRASS, M.D.

REFERENCES

Bahler RC, Rakita L: Cardiovascular findings in potassium-depleted dogs. Am Heart J 81:650-657, May 1971

Daniell HW: Arrhythmia in hypokalemia. N Engl J Med 284: 1385, June 17, 1971